Ready Set Smile
Laura B. McAuley, DDS
PEDIATRIC DENTISTRY

Patient Medical History | **Patient Name:** ______________

Does this patient have or has he/she had any of the following diagnosed by a Physician?

	YES	NO	WHEN		YES	NO	WHEN
ADD or ADHD	__	__	____	Heart Murmur	__	__	____
Allergies	__	__	____	Rheumatic Fever	__	__	____
Anemia/Blood Problems	__	__	____	Hole in Heart	__	__	____
Sickle Cell Anemia	__	__	____	Heart Trouble	__	__	____
Hemophilia	__	__	____	High/Low Blood Pressure	__	__	____
Asthma	__	__	____	Hepatitis/Liver Problems	__	__	____
Blood Transfusion	__	__	____	HIV/AIDS	__	__	____
Cancer	__	__	____	Kidney Problems	__	__	____
Developmental Delays	__	__	____	Painful or Swollen Glands	__	__	____
Diabetes	__	__	____	TB	__	__	____
Epilepsy/Seizures	__	__	____	Stroke	__	__	____
Fainting/Dizzy Spells	__	__	____	Emotional/Neurological Problems	__	__	____
Premature Birth	__	__	____				
Thyroid Problems	__	__	____	Other: ______________________________			

Does this patient have a history of the following?

	YES	NO		YES	NO		YES	NO
Grinding teeth	__	__	Tongue Thruster	__	__	Drinks in Bed	__	__
Nail Biting	__	__	Pacifier Use	__	__	Nursing/Bottle past 12 months	__	__
Mouth Breathing	__	__	Thumb/Finger Sucker	__	__			

Is this patient CURRENTLY taking any medications or vitamins? YES NO
If yes, please list: ____

Does this patient have a physical impairment? (Ex: Blindness, Deafness, Paralysis, etc.) YES NO
If yes, please specify: ____

Does this patient have any syndrome or any long term medical condition? YES NO
If yes, please specify (Ex: Downs, Autism, OCD,MS, CP, ETC.)______________________________

Has this patient been hospitalized in the past two years? YES NO
If yes, when and why? ____

Has this patient ever experienced ill effect from a local anesthetic or medication? YES NO
If yes, please describe (Ex: Itching, Rash, Swelling, etc.) ______________________________

Patients Medical Doctor: ____________________ **Phone Number:** ____________________
Date of last visit (Month/Year):_______ /________ Reason:______________________________

Has this patient ever been to the dentist? YES__ NO__
If YES, date of last visit ____/____/____
Was the experience positive? YES NO

How often does patient brush? __________ **Floss?** __________ **By whom?** ____________________
Are there any concerns about this patient's teeth or mouth? YES NO
If yes, please explain: ____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the health of this patient. I will not hold Dr. McAuley or any of her staff responsible for any errors or omissions that I may have made during the completion of this form.

______________________________________ ____________________
Signature of Parent or Legal Guardian Date